IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 70070710000279790185

November 26, 2008

John Schulkins, Administrator
Caldwell Care Center
210 Cleveland Boulevard
Caldwell, ID 83605

Provider #: 135014

Dear Mr. Schulkins:

On **November 21, 2008**, a Facility Fire Safety and Construction survey was conducted at Caldwell Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 9, 2008**. Failure to submit an acceptable PoC by **December 9, 2008**, may result in the imposition of civil monetary penalties by **December 29, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **December 26, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 26, 2008**. A change in the seriousness of the deficiencies on **December 26, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 26, 2008** includes the following:

Denial of payment for new admissions effective **February 21, 2009**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 21, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 21, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **December 9, 2008**. If your request for informal dispute resolution is received after **December 9, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Mark P. Grimes
Supervisor
Facility Fire Safety and Construction

MPG/lj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135014	A. BUILDING 01 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALDWELL CARE CTR	210 CLEVELAND BLVD CALDWELL, ID 83605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story , Type V(111) construction. The facility is fully sprinklered with a complete fire alarm system with the exception of full smoke detection coverage. There is a small basement where the hot water heaters are located. The facility was built in 1947 and currently licensed for 71 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on November 21, 2008. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with 42 CFR 483.70. The Survey was conducted by: Tom Mroz Health Facility Surveyor Fire/Life Safety Eric Mundell, REHS Health Facility Surveyor Fire/Life Safety	K 000	RECEIVED DEC 0 9 2008 FACILITY STANDARDS	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Chalhoun	Executive Director	12/9/2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	Continued From page 1 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This Standard is not met as evidenced by: Based on observations the facility did not ensure that the corridor doors between the dining room and the employee break room properly latched. The facility had a census of 64 on the day of the survey. Findings include: During the facility tour on November 21, 2008 at 10:12 a.m., observation determined that the cross-corridor doors between the dining room and the employee break room would not close completely. This was observed by the surveyors and the facility administrator. This deficiency affected all residents and staff present on the day of the survey. This deficiency would not have the ability to slow fire growth and smoke spread and provide more time for the residents to evacuate should a fire start on either side of the doors.	K 018	**Specific Doors** The cross-corridor doors between the dining room and employee break room have been repaired to appropriately close. **Other Doors** Doors for the remainder of the building were reviewed for needs. Repairs were made as appropriate. **Facility Systems** The Maintenance Director will round in the building at least monthly to review conditions of doors. Areas needing addressed will be repaired. **Monitor** The ED or designee will round with the Maintenance Director and make observations in facility to monitor for compliance. Any issues will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as indicated. **Date of Compliance** December 26, 2008	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to	K 056		

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K 056	Continued From page 2 provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured that automatic fire sprinklers shall not be obstructed from proper distribution of water. The census was 64. The findings include: Observation on November 21, 2008 at 9:53 a.m., disclosed that the sprinkler head in the oxygen room was obstructed by a newly installed ventilation duct. In the event of fire the obstruction would prevent the proper distribution of water. This was observed by the surveyors and the facility administrator. Lack of clearance would create obstruction to put out fire.	K 056	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Specific Area Cited** The sprinkler head were moved in named area. **Other Areas** Sprinkler heads for the remainder of the building were reviewed for needs. Repairs were made as appropriate. **Date of Compliance** December 26, 2008	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by:	K 130		

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K 130	Continued From page 3 NFPA 101, Chapter 4, Section 4.6.12.2 - Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. Based on observations during the facility tour as well as review of the annual fire alarm inspection report dated June 3, 2008 it was determined that the facility failed to remove existing life safety devices that are no longer required. The facility had a census of 64 residents on the day of the survey. The findings included: During the tour of the facility on November 21, 2008 at 9:46 a.m. observation revealed a fire alarm control panel and heat detectors that were no longer in service and/or connected to the newly installed fire alarm control panel. The facility annual fire alarm system inspection report dated June 3, 2008 stated that heat detectors no longer connected to the fire alarm system should be removed. This was observed by the surveyors and the facility administrator. This deficiency affected all residents and staff present on the day of the survey. This condition would create a reasonable expectation by the public that these safety devices are functional. When systems are inoperable or taken out of service but the devices remain, they present a false sense of safety.	K 130	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Plan of Correction** The heat detectors and alarm control panel no longer in use were removed. **Date of Compliance** December 26, 2008	

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story , Type V(111) construction. The facility is fully sprinklered with a complete fire alarm system with the exception of full smoke detection coverage. There is a small basement where the hot water heaters are located. The facility was built in 1947 and currently licensed for 71 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on November 21, 2008. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with IDAPA 16.03.02 The surveyors conducting the survey were: Tom Mroz Health Facility Surveyor Fire/Life Safety Eric Mundell Health Facility Surveyor Fir/Life Safety	C 000	RECEIVED DEC 09 2008 FACILITY STANDARDS	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are	C 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/9/2008

Bureau of Facility Standards

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C 226	Continued From Page 1 applicable to health care facilities. This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567: 1. K018 Doors protecting the corridor. 2. K056 Installation of sprinkler system. 3. K130 Miscellaneous	C 226	Refer to plan of correction for corresponding Federal "K" tags on the CMS – 2567: K018, K056, K130.	